SERFF Tracking Number:	*USLH-128316118*	*State:*	*Arkansas*
Filing Company:	*United Security Life and Health Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*EZTL-12APP*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*EZ Term Life Insurance*		
Project Name/Number:	*EZ Term Life Insurance/*		

Filing at a Glance

Company: United Security Life and Health Insurance Company

Product Name: EZ Term Life Insurance	SERFF Tr Num: USLH-128316118	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num: EZTL-12APP	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Jaime Gettemans, Peg Lundy	Disposition Date: 05/08/2012
	Date Submitted: 05/01/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: EZ Term Life Insurance	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: Resubmission	Previous Filing Number: USLH-128129568
Individual Market Type:	Overall Rate Impact:
Filing Status Changed: 05/08/2012	
State Status Changed: 05/08/2012	Deemer Date:
Created By: Peg Lundy	Submitted By: Peg Lundy

Corresponding Filing Tracking Number:

Filing Description:

Please see attached cover letter for details regarding this filing. Thank you very much!

State Narrative:

Company and Contact

SERFF Tracking Number:	*USLH-128316118*	*State:*	*Arkansas*
Filing Company:	*United Security Life and Health Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*EZTL-12APP*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*EZ Term Life Insurance*		
Project Name/Number:	*EZ Term Life Insurance/*		

Filing Contact Information

Peg Lundy, plundy@unitedsecuritylandh.com
6640 S. Cicero Avenue 708-475-6025 [Phone]
Bedford Park, IL 60638

Filing Company Information

United Security Life and Health Insurance Company	CoCode: 81108	State of Domicile: Illinois
6640 S. Cicero	Group Code:	Company Type:
Bedford Park, IL 60638	Group Name:	State ID Number:
(708) 475-6000 ext. [Phone]	FEIN Number: 36-3692140	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50.00 per fprm - 2 forms totaling $100.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Security Life and Health Insurance Company	$100.00	05/01/2012	58833371

SERFF Tracking Number:	*USLH-128316118*	*State:*	*Arkansas*
Filing Company:	*United Security Life and Health Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*EZTL-12APP*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*EZ Term Life Insurance*		
Project Name/Number:	*EZ Term Life Insurance/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/08/2012	05/08/2012

SERFF Tracking Number:	*USLH-128316118*	*State:*	*Arkansas*
Filing Company:	*United Security Life and Health Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*EZTL-12APP*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*EZ Term Life Insurance*		
Project Name/Number:	*EZ Term Life Insurance/*		

Disposition

Disposition Date: 05/08/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*USLH-128316118*	*State:*	*Arkansas*
Filing Company:	*United Security Life and Health Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*EZTL-12APP*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*EZ Term Life Insurance*		
Project Name/Number:	*EZ Term Life Insurance/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Form	Schedule of Benefits		Yes

SERFF Tracking Number:	*USLH-128316118*	*State:*	*Arkansas*
Filing Company:	*United Security Life and Health Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*EZTL-12APP*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*EZ Term Life Insurance*		
Project Name/Number:	*EZ Term Life Insurance/*		

Form Schedule

Lead Form Number: EZTL-12APP

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	EZTL-12POL-AR	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: EZTL-12POL-AR - Revised 4.24.12 Previous Filing #: EZTL-12POL-AR		Schedule Page - EZTL-12POL-AR.pdf

SCHEDULE PAGE

Primary Insured	[John Doe]
Issue Date	[3-1-2012]
Policy Number	[12345678]
Issue Age	[35]
Sex and Class	[Male Standard Non-Tobacco User]
Initial Term Period	[10] years
Face Amount	[$50,000]
Initial Total Premium*	[$173.00] Premium Mode [Annual]
Initial Premium Guarantee Period	[5] years

* Does not include the Billing Fee.

[Guaranteed Maximum Premium for Remainder of Initial Term Period [$213.00]]
After the Initial Term Period ends, the Term Period becomes annual to age 95. See Page 4 for Guaranteed Maximum Premium applicable after Initial Term Period.

Expiry Date	[2-28-2072]

Additional Benefits

Spouse Rider	Amount [$25,000]
Spouse Sex and Class	[Female Standard Non-Tobacco User]
Child Rider	Amount [$10,000]

Basis of Values

INTEREST RATE FOR RESERVES:	[4.00%]
VALUATION METHOD:	COMMISSIONER'S RESERVE VALUATION METHOD
MORTALITY TABLE:	2001 CSO MALE or FEMALE, NONSMOKER or SMOKER, AGE LAST BIRTHDAY

Policyholder Service Office Company: United Security Life and Health Insurance Company
Address: 6640 South Cicero Avenue, Bedford Park, IL 60638
Telephone Number: 1-800-475-4422
Name of Agent: [John Doe]
Address: [1234 Insurance Avenue, Little Rock, Arkansas 72201]
Telephone Number: [501-123-4567]

If we at United Security Life and Health Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2640 or (800) 852-5494

SERFF Tracking Number:	*USLH-128316118*	*State:*	*Arkansas*
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Product Name:	*EZ Term Life Insurance*		
Project Name/Number:	*EZ Term Life Insurance/*		

Supporting Document Schedules

Item Status: **Status Date:**

Bypassed - Item: Flesch Certification
Bypass Reason: Formally submitted and approved.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Application revised.
Attachment:
EZ Term Life Application - EZTL-12APP - Revised 4.24.12.pdf

Item Status: **Status Date:**

Bypassed - Item: Life & Annuity - Acturial Memo
Bypass Reason: Formally submitted for Informational Purposes Only and filing was approved.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Cover Letter
Comments:
Please see attached Cover Letter for details regarding this filing. Thank you very much for your time and efforts!
Attachment:
5.1.12 - Cover Letter (EZ Term Life Product) - AR.pdf

APPLICATION FOR EZ TERM LIFE INSURANCE WITH
UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY
6640 South Cicero Avenue, Bedford Park, Illinois 60638
1-800-875-4422 **www.uslandh.com**
Fax number: (708) 475-6120

PART ONE

A. Primary Proposed Insured (PPI)

1. Name (First, Middle Initial, Last)	2. SS/Tax ID No.	3. Birthplace (State/Country)
4. Residence Address (Including City, State & Zip)	5. Business Address (Including City, State & Zip)	
6. Residence Phone Number: ( )	7. Cell Phone Number: ( )	
8. Driver's License No./State / 9. Occupation and Nature of Duties	10. Annual Income	11. Employer
12. Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	13. Email Address	

B. All Proposed Insureds (List PPI first, then spouse and children, if applicable. For additional applicants, please list on a separate, signed sheet.)

First Name Middle Last	SS/Tax ID No.	Relation to PPI	Sex M/F	Date of Birth Mo/Day/Yr	Birthplace State/Country	Height Ft. In.	Weight Lbs.
1		PPI					
2							
3							
4							
5							

C. Plan of Insurance

Amount ($20,000-$250,000)	Plan	Rate Guarantee Option	Age of PPI (Last Birthday)	Requested Effective Date	Payment Mode:
$	☐ 10 yr ☐ 20 yr ☐ 30 yr	☐ Full Term ☐ Five Year Guarantee*			☐ Annual $0 ☐ Semi-Annual $6 ☐ Quarterly $5 ☐ Monthly Direct $3 ☐ Credit Card $1 ☐ PAC $1

* Your rate may be increased after 5 years. Any increase will be on a uniform class basis and will never exceed the guaranteed maximum premium stated in the policy.

Modal Premium: $		
Benefits/Riders	☐ Spouse Insurance Rider $ ($10,000 - $75,000) Cannot exceed ½ of PPI Amount	☐ Children's Insurance Rider $ ($5,000 - $25,000) Cannot exceed ¼ of PPI Amount

Credit Card Number / _____/ ☐ Visa ☐ MasterCard ☐ Discover Exp. Date _____/

EFT Authorization As a convenience to me, I hereby request and authorize you to pay and charge my account (check or electronic debit) drawn on my account by and payable to United Security Life & Health Insurance Company, provided there are sufficient funds in said account to pay the same on presentation. I agree that your rights with respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I further agree that if any such check or electronic debit be dishonored, whether with or without a cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization is to remain in effect until revoked by me in writing, and until you actually receive such notice.

/_____/ Bank Name / /_____/ Bank Address

/_____/ Bank Account Number / /_____/ Routing Number

/_____/ Printed Name of Depositor / /_____ / /_____/ Signature of Depositor Date

D. Life Insurance in Force on All Proposed Insureds: ☐ None ☐ Listed Below

Insured	Issue Year	Company	Face Amount

E. Beneficiary Designation

Full Name and Address of Primary Beneficiary(ies)	Social Security/Tax ID No.	Date of Birth	Relationship to PPI	Percent of Proceeds

Full Name and Address of Contingent Beneficiary(ies)	Social Security/Tax ID No.	Date of Birth	Relationship to PPI	Percent of Proceeds

F. Owner, if other than Primary Proposed Insured

Full Name	Social Security/Tax ID No.	Date of Birth	Relationship to PPI
Address, if other than Primary Proposed Insured's			

Contingent Owner

Full Name	Social Security/Tax ID No.	Date of Birth	Relationship to PPI
Address, if other than Primary Proposed Insured's			

G. Payor, if other than Primary Proposed Insured

Full Name	Social Security/Tax ID No.	Date of Birth	Relationship to PPI
Address, if other than Primary Proposed Insured's			

SPECIAL REQUESTS OR INSTRUCTIONS

H. General Information

The following questions pertain to all Proposed Insureds, including children.	*Yes*	*No*	*Explain fully all "Yes" answers. Indicate question number and the name of the Proposed Insured.*
1. Is the insurance applied for intended to replace any existing insurance or annuity contract? (If "YES", enclose all required replacement forms.)	☐	☐	
2. Are there any application(s) for any life or health insurance now pending with any company?	☐	☐	
3. Has any Proposed Insured ever had an application for life insurance declined, postponed, rated or modified?	☐	☐	
4. Is any Proposed Insured NOT a United States citizen? If "YES", provide immigration card number_____	☐	☐	
5. Has any Proposed Insured ever received or claimed disability or a pension for any injury, sickness or impaired condition?	☐	☐	
6. Within the past 3 years, has the Proposed Insured flown in a plane other than as a passenger on a commercial airline or does he or she have plans for such activity within the next year? If "YES", please complete a separate Aviation Risk Supplement form for the Proposed Insured.	☐	☐	
7. Within the past 3 years, has the Proposed Insured participated in or does he or she plan to participate in any of the following? Underwater sports, - scuba diving, skin diving or similar activities, Racing sports – motorcycle, auto, motor boat or similar activities, Sky sports – skydiving, hang gliding, parachuting, ballooning or similar activities, Rock or mountain climbing or similar activities, Bungee jumping or similar activities. If "YES", please describe in the space provided to the right.	☐	☐	
8. Does any Proposed Insured have any intention of traveling or living outside the USA or Canada in the next 2 years, except for vacation?	☐	☐	
9. In the past 5 years, has any Proposed Insured been convicted of 2 or more moving violations or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked? (If "YES", give details.)	☐	☐	
10. In the past 10 years, has any Proposed Insured used marijuana, cocaine, heroin, barbiturates, hallucinogens, or amphetamines, except on the advice of a physician, or been convicted for the use or possession of alcohol; or received advice, counseling or treatment as the result of the use of alcohol or drugs; or used or been convicted for the use or possession of any narcotic, stimulant, sedative, or hallucinogenic drug?	☐	☐	
11. In the past 10 years, has any Proposed Insured been convicted of a felony?	☐	☐	

I. Physical Data, Health and Medical History

The following questions pertain to all Proposed Insureds, including children, (Check ALL applicable items)	*Yes*	*No*	*Explain fully all "Yes" answers. Include name of Proposed Insured and question number the answer applies to, specific diagnosis, treatments, results, dates of onset & recovery, and names & addresses of all doctors & hospitals.*
1. (a) Does any Proposed Insured currently use tobacco in any form? (If "yes", describe tobacco use below.) Who? _____ ☐ Cigarettes ___packs per day ☐ Cigars ☐ Pipe ☐ Chewing or other "smokeless" tobacco	☐	☐	
(b) Is any Proposed Insured a former user of tobacco? (If "yes", describe tobacco use below.) Who? _____Month/Year quit_____ Describe past use of tobacco_____	☐	☐	
2. Has any Proposed Insured ever been diagnosed with or treated for:			
(a) high blood pressure, chest pain or pressure, angina, heart attack, abnormal heartbeat, murmur, stroke, or any other circulatory system disorder?	☐	☐	
(b) cancer, Hodgkin's disease, leukemia, or any tumor or polyp?	☐	☐	
(c) seizures, convulsions, migraine headaches/chronic severe headaches, head injury, paralysis, tremor, stroke, TIA, multiple sclerosis, bi-polar, psychosis, Parkinson's, restless leg syndrome, Lou Gehrig's disease (ALS) or or any other mental or nervous disorder?	☐	☐	
(d) organ or bone marrow transplant?	☐	☐	
(e) obesity or weight loss surgery?	☐	☐	
3. In the past 10 years, has any Proposed Insured had or been treated for:			
(a) diabetes, anemia, polycythemia, hemophilia; disorder or enlargement of any gland, including lymph glands or thyroid disorder?	☐	☐	
(b) persistent fever, cough, diarrhea, weakness or infection?	☐	☐	
(c) asthma, bronchitis, emphysema, tuberculosis, pneumonia, or any infection or other disorder of the respiratory system?	☐	☐	
(d) ulcer, gastritis, colitis, hepatitis, cirrhosis, pancreatitis, or any other disorder of liver, gallbladder, or intestines?	☐	☐	
(e) any disorder of the kidneys, bladder, prostate, reproductive organs or breasts; or any sexually transmitted disease?	☐	☐	
(f) any disorder of the back, spine, bones, joints or muscles or Rheumatoid Arthritis?	☐	☐	
4. In the past 10 years has any Proposed Insured:			
(a) been diagnosed by a member of the medical profession as having, or been treated for, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV disease?	☐	☐	
(b) tested positive for antibodies to the HIV virus?	☐	☐	
5. In addition to any doctors or hospitals listed above, in the last 5 years, has any Proposed Insured:			
(a) been treated, examined or observed in a hospital, clinic, or other medical facility?	☐	☐	
(b) consulted with any other doctors?	☐	☐	
(c) been treated for, diagnosed as having, or had an operation for any other cause(s) not listed above?	☐	☐	
(d) been advised by a medical professional to have surgery, treatment, testing, or hospitalization and have not done so?	☐	☐	
6. Within the past year, has the weight of any Proposed Insured changed 10 pounds or more? (For children under 16, report only loss)	☐	☐	
7. Have two or more of Proposed Insured's immediate family (parents, siblings) had heart disease, stroke or diabetes prior to their age 60?	☐	☐	

PPI'S Family History	*Living: Age*	*Deceased: Age at Death*	*Cause of Death*
Father			
Mother			
Brother			
Sisters			

REMAINDER OF THE PAGE LEFT BLANK INTENTIONALLY

AGREEMENT: I have read this application, and represent that all of the information given in it is true, complete and correctly written to the best of my knowledge and belief. It is agreed that:

A. The application consists of Part One, Part Two (if required), and any amendments or supplements to either of said parts. It will be relied on by United Security Life and Health Insurance Company ("United Security") as the basis of any policy which may be issued.
B. No agent, broker, or medical examiner can accept risks, make or change contracts, or waive any of United Security's rights, conditions, or requirements. Only an authorized officer of United Security can do these things.
C. Except as may be provided by the Conditional Receipt, there will be no insurance unless and until a policy is delivered and the first modal premium paid in full while the insurability of the Proposed Insured(s) is still as described in the application; I will inform the Company of any changes in my or any proposed insured's health, mental or physical condition, or of any changes to any answers on this application, prior to or upon delivery of this policy.
D. If the Conditional Receipt is delivered to the Applicant, insurance will start before a policy is delivered only if all the conditions set forth in such receipt are met. If I have received such receipt, its provisions have been explained to me and I fully understand them.
E. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for Home Office "Corrections and Additions". But where the law so requires, written consent must be obtained for any change in the application.

BACKUP WITHHOLDING CERTIFICATION (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, pharmacy, pharmacy benefits manager or other pharmacy related services organization, claims administrator, employer, insurer or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, prescription information, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me or my minor children, to give such information to United Security or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except Medical Information Bureau, Inc., to give such information to any agent or insurance support organization acting for United Security or its reinsurer(s).

Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by United Security, to its reinsurer(s), the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I agree that a photocopy of this form will be as valid as the original. I understand that I have the right to revoke this authorization in writing at any time, by sending a written request for revocation to USL&H, P.O. Box 388342, Chicago, Illinois 60638. Attention Privacy Officer. I also agree that this form will be valid for (1) 30 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices", "Investigative Consumer Reports", and "Medical Information Bureau, Inc." from United Security.

WARNING: Any person who, with intent to defraud or knowing that she/he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

Signature of Primary Proposed Insured (if minor, parent or legal guardian)	*** * * Date Signed * * ***	Signature of Agent
Signature of Spouse, if a Proposed Insured	Signature of Other Proposed Insured (if age 15 or over)	Agent's Printed Name / Agent No.
Signature of Proposed Owner (if not Primary Proposed Insured)	Signature of Other Proposed Insured (if age 15 or over)	Agent's License No. / State
Signature of Other Proposed Insured (if age 15 or over)	Signature of Other Proposed Insured (if age 15 or over)	Signed at (City,State,Zip)

CONDITIONAL RECEIPT

Unless every condition in paragraph 2 is met exactly, no insurance will take effect prior to policy delivery. No agent, broker, or medical examiner is authorized to change or waive any of such conditions. If, within the past 12 months, any Proposed insured has had or been treated for any known heart trouble, stroke, AIDS or cancer, payment cannot be accepted with the application.

All checks must be made payable to United Security Life and Health Insurance Company. Do not make check payable to the agent or leave the payee blank.

Received from_____ $_____ cash

given with application for life insurance to United Security Life Insurance Company (United Security), which application bears the same date as this receipt. This receipt is void if the item given for it fails to result in payment.

1. If all the conditions in Paragraph 2 are met exactly, then insurance subject to the terms of the policy applied for, but not to exceed the limit in Paragraph 3, will start at the "Conditional Effective Time", defined as the later of: (a) when Part One of the application has been completed; or (b) when all medical exams and tests required by United Security's rules have been completed, and all required blood, urine, and/or oral fluid specimen(s) have been furnished.
2. Insurance will not start at the Conditional Effective Time unless all these conditions are met:
   (a) At the Conditional Effective Time, all of the Proposed Insureds must be risks acceptable to United Security under its rules, limits, and standards of insurability for the amount and plan applied for, without change, and at the standard rate of premium.
   (b) The sum of money, if any, given for this receipt must be at least as much as the full first premium for the plan, amount of insurance and the mode of payment stated in the application.
   (c) All medical exams and tests required by United Security' s rules must be completed, and all required specimens of blood, urine, and/or oral fluid specimen(s) furnished, within 60 days from the date of Part One of the application.
   (d) At the Conditional Effective Time, the state of health and all factors affecting the insurability of the Proposed Insured(s) must be as stated in the application.
3. The total amount of life insurance, including accidental death benefits, which may become effective on any Proposed Insured prior to the effective date of a delivered policy for which the full first premium has been received by reason of this and any other receipts, will not exceed $50,000.
4. If one or more of the conditions in Paragraph 2 is not met exactly, or if death of a Proposed Insured results from suicide, there will be no liability on the part of United Security except to return any money received.

I certify that I have explained all of the terms of this receipt to the Applicant(s).

Date: _____ X_____
Signature of Agent

The following is a copy of the Agreement signed in connection with the application.

AGREEMENT

AGREEMENT: I have read this application, and represent that all of the information given in it is true, complete, and correctly written to the best of my knowledge and belief. It is agreed that:

A. The application consists of Part One, Part Two (if required), and any amendments or supplements to either of said parts. It will be relied on by United Security as the basis of any policy which may be issued.

B. No agent, broker, or medical examiner can accept risks, make or change contracts, or waive any of United Security's rights, conditions, or requirements. Only an authorized officer of United Security can do these things.

C. Except as may be provided by the Conditional Receipt, there will be no insurance unless and until a policy is delivered and the first modal premium paid in full while the insurability of the Proposed Insured(s) is still as described in the application; there must have been no material change in health or other risk factors. I will notify United Security if any such change takes place after I sign the application and before such delivery and payment.

D. If the Conditional Receipt is delivered to the Applicant, insurance will start before a policy is delivered only if all the conditions set forth in such receipt are met. If I have received such receipt, its provisions have been explained to me and I fully understand them.

E. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for Home Office "Corrections and Additions". But where the law so requires, written consent must be obtained for any change in the application.

AGENT'S REPORT AND CERTIFICATE

		Yes	No
1.	Is the Applicant or any Proposed Insured a current or past United Security policyowner or Insured?	☐	☐
2.	As far as you know, will the insurance applied for replace any existing insurance or annuity?	☐	☐
	If "Yes", did you write the replaced policy?	☐	☐
	Reason(s) for replacement:		
3.	Are there any Proposed Insureds whom you did not see when you took this application?	☐	☐
4.	Are there any Proposed Insureds who do not reside with the Primary Proposed Insured?	☐	☐
5.	Have you submitted or do you plan to submit this case to any other company?	☐	☐
6.	Has any Proposed Insured used a different last name in the past 5 years? (Provide full details of all "Yes" answers)	☐	☐

7. To clarify any question or obtain a telephone interview, the following is needed **(Please remind the Primary Proposed Insured about the possibility of a call)**:

   Home Telephone: (_____) _____ Best time to call _____

   Cell Telephone: (_____) _____ Best time to call _____

8. Indicate below how well you know the Primary Proposed Insured (Applicant, if Primary Proposed Insured is under age 18).

   ☐ Slightly for ____ years ☐ Well for ____ years ☐ Just met ☐ Related by blood or marriage; he/she is my _____

9. Is medical exam or blood profile required? ☐ Yes ☐ No

   Date Scheduled _____ Paramed/Examiner _____

10. If Primary Proposed Insured is below 18, how much life insurance is in force and applied for on:

    Mother _____ Father _____ Siblings _____

11. Request for ☐ Additional ☐ Alternate policy.

    Plan _____ Amount _____ Benefits _____

    Beneficiary _____ Other Differences _____

12. Source of Prospect

    ☐ Existing Client ☐ Relative of Client ☐ Referred Lead ☐ Personal Acquaintance for _____ years.

    ☐ Cold Canvas ☐ Direct Mail ☐ Prospect approached me without being solicited

AGENT'S REPORT AND CERTIFICATE

13. Use of Insurance (check one)

☐ Personal (If checked, complete question 14) ☐ Business Related (If checked, complete question 15)

14.a Purpose of Personal Insurance with expectation of how proceeds will be utilized (check one most applicable)

☐ Create an Immediate Estate for Heirs ☐ Surviving Income Protection
☐ Retirement Income Supplement ☐ Provide Estate Liquidity
☐ Mortgage Protection/Acceleration ☐ Secure Other Personal Debt
☐ Supplement and Protect Personal Savings ☐ Other_____

14.b How was amount of Personal Insurance determined? (check one most applicable).

☐ Needs Analysis with Assistance from Agent ☐ Needs Analysis with Computer Output Assistance
☐ Need Pre-Determined by Applicant ☐ Other_____

15.a Purpose of Business Insurance (check one most applicable).

☐ Business Continuation Plan (Buy/Sell) ☐ Key Person Plan ☐ Deferred Compensation Plan
☐ Split Dollar Plan ☐ Executive Bonus Plan ☐ Secure Business Debt
☐ Other_____

15.b Business Data ☐ Corporation ☐ Partnership ☐ Sole Proprietorship

If available, attach a copy of the business' latest audited financial statements (Balance Sheet and Profit and Loss).
In addition, please complete the following questions:

i. Date Corporation, Partnership or Business Established_____
ii. Estimated Net Worth of Business $_____
iii. Current Value of Primary Proposed Insured's Interest (based on % of ownership) $_____
iv. Net Annual Income of Business $_____
v. If Proposed Insured is an officer or partner, are all of the remaining officers or partners applying for insurance at this time? ☐ Yes ☐ No (If "No", explain in remarks.)

REMARKS _____

I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of any person proposed for insurance which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices, the Federal Fair Credit Reporting Act, and Medical Information Bureau, Inc., were given to the Primary Proposed Insured.

Date	Agent's Signature	Joint Agent's Signature
	Agent's Printed Name/ Agent No.	Joint Agent's Printed Name/ Agent No.
	Agent's License No./State	Joint Agent's License No./State
	Agent's Phone Number	Joint Agent's Phone Number

UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY
6640 South Cicero Avenue, Bedford Park, Illinois 60638
1-800-875-4422 **www.uslandh.com**
Fax number: (708) 475-6120

NOTICE UNDER THE FAIR CREDIT REPORTING ACT AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

INVESTIGATIVE CONSUMER REPORTS: As part of the underwriting process, we may request an investigative consumer report from a consumer reporting agency for the purpose of obtaining information about your character, reputation and mode of living, through personal interviews with your friends, neighbors, and associates. You may ask for a personal interview with the consumer reporting agency in connection with any investigative consumer report which may be prepared. You are also entitled, upon written request pursuant to law, to be informed of the nature and scope of the investigation and to receive a copy of the report.

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

For further information, write the Underwriting Department, United Security Life and Health Insurance Company, 6640 South Cicero Avenue, Bedford Park, Illinois 60638.

UNITED SECURITY
LIFE AND HEALTH INSURANCE COMPANY

May 1, 2012

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

RE: Company ID #205611
NAIC #81108 / FEIN # 36-3692140

EZTL-12APP - Revised - 4.24.12 / Application for EZ Term Life Insurance
Schedule of Benefits – EZTL-12POL-AR / Schedule of Benefits

To Whom It May Concern:

Recently, we filed and received approval for a new product, the EZ Term Life Product (Serff Tracking Number USLH-128129568/Approved 03/12/2012). That filing included the Policy, Application, Additional Riders and Actuarial Memorandum for the new product. Since its approval, we have not placed this product on the market. While we were in the process of going to market, we decided to make some changes to the Application and the Schedule of Benefits page. Therefore, the enclosed filing is being filed as a resubmission to the original application EZTL-12APP-AR and the original Schedule of Benefits page that was filed as part of the Policy, EZTL-12POL.

The revised Application **(EZTL-12APP-Revised - 4.24.12)** was revised to include a new option for either a 5 year guarantee on rates or a lifetime guarantee on rates. The revised Schedule of Benefits – **(Schedule of Benefits – EZTL-12POL-AR)** was revised to include variable language for if an insured elects the Spouse or Dependent Rider. The Riders were approved in the original filing.

Again, these products have not gone to market, so we have not used the originally filed forms.

We look forward to your approval. If you should have any questions, feel free to contact me directly at (708) 552-2417 or via email at jaimegettemans@priscorp.net.

Sincerely,

Jaime Gettemans

Jaime Gettemans
Compliance Department